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ABSTRACT

This paper explores the strengths and weaknesses of the medical model in an effort to promote a counseling perspective that embraces some of the medical model's strengths. Through inclusion, rather than exclusion, it is believed that the counseling model will eventually infiltrate the medical model by way of its own documentation system. With its emphases on individual differences, quality over production, the power of belief, and the psychological needs of its clients, the counseling model provides a holistic approach to treating individuals. It is theorized that the union of these two models will provide a healthy synthesis of approaches that will benefit everyone in the long run. (Author)

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Defending The Counseling Model

And Its Eventual Synthesis With The Medical Model

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Abstract

This paper explores the strengths and weaknesses of the medical model in an effort to promote a counseling perspective that embraces some of the medical model's strengths. Through inclusion rather than exclusion, it is believed that the counseling model will eventually infiltrate the medical model by way of its own documentation system. With its emphases on individual differences, quality over production, the power of belief, and the psychological needs of its clients, the counseling model provides a holistic approach to treating individuals. It is theorized that the union of these two models will provide a healthy synthesis of approaches that will benefit everyone in the long run.

Defending The Counseling Model

And Its Eventual Synthesis With The Medical Model

Kane describes the medical model as "standing for all the failures of a highly specialized, technological, and expensive medical care system in meeting the needs of its patients" (1982, p. 315). "On an individual level, it connotes an emphasis on diagnoses rather than people" (Kane, 1982, p. 315). Had I began writing this paper several weeks ago, I would have cried foul, defending the use of the medical model and encouraging its continued use. However, as certain changes have occurred within my own life, I must stand in defense of Kane's definition as listed above. Please note that I am not saying we eliminate the use of the medical model all together; however, I do feel that it can be improved upon in order to take a more holistic view of individuals as would the counseling model. An eventual synthesis of the competing models is proposed as the eventual goal, since it is unlikely that a competing model, such as the counseling perspective will replace the medical model over night.

The Individual as Organism, Procedure, and Diagnosis

The most alarming problem with the medical model is its blatant disregard for the individual's values, beliefs, past experiences, and/or psychological needs. Instead of treating an individual as a human being with individual personal concerns and fears, the medical model serves to treat individuals as organisms, classifying each of them according to gender, sex, ethnicity, and diagnosis. Using a counseling approach to treatment, we can begin to see the individual in a different light, taking into account his or her personal concerns and addressing our clients individually.

Kane (1982) feels that the medical model should be used to provide reproducible results in other areas outside of the medical profession, such as counseling and other forms of therapy.

> When physicians prescribe a drug, they do so with explicit guidelines that include criteria for the drug use, dose duration, contraindications, and potential side effects. In contrast, social workers are prone to nonspecific prescriptions such as group therapy or crisis intervention (Kane, 1982, p. 317).

Kane (1982) feels counseling could be more scientific in nature, but to do so would treat everyone in the same manner, ignoring individual differences.

Warshaw (1989) conducted a study of battered women who had sought treatment in a large public hospital. According to Warshaw, "the physician selectively attends to the 'medical facts' rather than the 'facts of the lifeworld'" (1989, p. 513). The medical model can only reduce things to categories it can handle and control (Warshaw, 1989). An analysis of the language used in medical records reveals how the medical model limits what happens between patients and doctors (Warshaw, 1989).

Warshaw's study also demonstrated that while many women will offer clues about being at risk for abuse, these clues were rarely acted upon by the attending physicians, even when they did make note of these concerns in the patients' charts (Warshaw, 1989). This study further revealed the lack of attention paid to the members of this study while in a hospital emergency room, even when formal protocols for recognizing abuse were in place (Warshaw, 1989). In 1/3 of the cases, physicians failed to probe for more detailed information regarding the patient's story for how the injury occurred, and in 92% of the cases, the medical discharge diagnosis did not reflect all the symptoms presented by the patients (Warshaw, 1989). Warshaw argues that the most potentially life threatening risk for the patient, that of ongoing domestic violence, was not indicated in the diagnosis or the disposition, despite its obvious presence on the chart and in the patient's history (Warshaw, 1989). Treating all patients with bruises, cuts, and/or broken bones in

the same fashion, may be the most efficient way to move people through the emergency room in a timely manner, but there is an overwhelming difference between an individual who has fallen down a flight of stairs versus one who has been repeatedly thrown down a flight of stairs.

In just the past week, my father has experienced the lack of personal attention provided by the medical model. After being hurriedly pushed through hospital admissions, he was routed to the radiology department, where he was to wait patiently for his appointment time. After waiting twenty minutes past his scheduled appointment time, he approached the inattentive receptionist who was still trying to locate his medical records from a previous appointment across the street. She disregarded his offer to retrieve the records himself. When he was finally taken into a back room for his appointment, no family members were allowed to accompany him to the testing area. No one was even allowed to stand outside of the doorway in the hall. Instead, he was to remain alone, facing the unknown, with no friend or family member to provide him any support. From the moment he stepped inside the hospital, he was simply another person, another organism, who needed to be diagnosed and controlled by the medical model. No variations in procedure or special considerations for current emotional state were tolerated. No one seemed to be cognizant of the fact that to many, a diagnosis of cancer is terrifying.

Belief and The Medical Model

In his book, May (1991) stresses the importance of myth or belief in treatment. Myth is defined by May (1991) as a belief system that may be religious, cultural, or individual in nature. Rollo May (1991) sees myth as essential to mental health. Myth provides a feeling of totality, carries the values of society, represents all of human experience; where rationality (empiricism) and the medical model leave us fragmented, relying on specificity (May, 1991). Myth gives us hope and helps us make sense of life, where the medical model often leaves the individual

feeling overwhelmed with medical jargon which soon becomes too complex for most to comprehend (May, 1991).

Flooded with facts, we become overwhelmed and lose our ability to feel (May, 1991). Myth cultivates empathy for others (May, 1991). In this age of technology, analytic thinking is stressed. We seem to worship machines and want to be like them: cold, logical, and productive. Surprisingly, the view among roboticists is that robots require some form of guiding belief or moral system, including emotions, preferences, goals, etc. in order to behave flexibly, enabling them to do a variety of tasks and respond to a variety of environmental events appropriately (Batson, 1990).

The counseling philosophy requires that we embrace the individual beliefs of our clients and approach them holistically. Beliefs provide personal identity, a sense of community, and a feeling of security (May, 1991). Nonwestern patients in Western hospitals often experience fear and sorrow (Bergman, 1973), because they feel as though they are abandoning their culture and beliefs. Unlike the medical model, our counseling philosophy would embrace the cultural aspects of an individual. The individual would be viewed as a unique person with his or her own particular needs. This would not be the standard treatment he or she would receive under the medical model's system of classification.

In Navajo healing rituals the whole family and even friends are involved in healing, showing the patient that he or she is cared for by others (Bergman, 1973), thus helping to relieve what fears and anxiety he or she may be feeling. As noted earlier, my own father was not afforded this simple gesture. Folk healers' respect for belief, provides them, with an edge that

allows them to quickly discover psychological conflicts their patients may have and proficiently resolve them (Bergman, 1973).

Inclusion or Exclusion: Weighing The Medical Model's Strengths

So, with this total disregard for the individual, why do professionals still seem to cling to the use of the medical model? It seems the medical model is currently the standard, while the use of educational, career, and preventive developmental approaches are currently being driven out of existence by the medical establishment (Sprinthall, 1990). Thus, one exclusionary belief system of sorts (the medical model) is driving competing systems of belief out of the mainstream. A blending or synthesis of approaches would seem to make more sense. An inclusionary approach, such as the counseling model, would be more practical in the long-term.

The medical model still exists in the writings of marriage and family counselors, despite the assertions that many of these writers make, indicating that this model has been abandoned (Laner, 1976). The medical model is sustained, either consciously or without intention, through the usage of a terminology, which is only appropriate within the model (Laner, 1976). Laner (1976) defends this argument by detailing the selection process used to make this determination. Citing no less than twenty-two articles from marriage and family counseling publications, Laner (1976) points out that medical language and terminology are still in use in contemporary counseling publications.

It is likely that we continue to embrace the medical model because it provides a common means of communication between professionals from different disciplines.

> Diseases are classified and so, too are treatments. Such classifications provide a common language for communication within the field and the basis for an

> organized body of knowledge about what is effective in treating various problems (Kane, 1982, p. 316).

If we as counselors plan on working with those in the medical environment in a collegial manner, then we need to speak a common language. We can learn this language from the medical model. In reading S.O.A.P. notes found in a medical record, we can easily follow the rationale behind the treatment being provided to a patient. This method of writing notes is common within the medical field and provides a uniform means of communication between professionals in the health practices.

Production Versus Quality

While I feel that we should treat each individual uniquely, I do feel that some situations are going to require similar treatments. Some uniformity in documentation and procedure makes sense. Perhaps, then we would progress more quickly to the root of the person's problems, providing them with effective treatment in a quicker, more cost-effective, and efficient manner. Kane's (1982) scientific emphasis on notation and set procedures for replication's sake makes sense from a production perspective but not from a quality perspective. There needs to be a synthesis of the two opposing forces of production and quality.

Despite the fact that the medical model has some severe problems in how it approaches the unique needs of individuals, I do feel that it does have some positive aspects. The medical model does provide a common means of communication with those in the health care professions. If all the members of a treatment team were able to communicate their concerns to each other effectively, then this would certainly be beneficial to the patient. This may even help facilitate a more holistic approach to treating each individual in the long run. So, the common means of communication that is provided by the medical model might be useful to those coming

from a counseling perspective. Some procedures may even be reproducible in certain situations from a production standpoint. Nevertheless, even if we adopt these characteristics of the medical model and mold them to fit our counseling philosophy, we must not forget to pay strict attention to the unique needs of those individuals whom we serve. By noting individual differences and the need for alternative treatment strategies in certain cases, a greater emphasis on quality of treatment may eventually infiltrate the medical model through their own notation system. For us to do this though, we will have to speak their language. Inclusion of some of the aspects of the medical model may truly be the only way a healthy 'dialectical synthesis' may be achieved.

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